

		FOR OHF USE					

LL 1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0046243</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Royal Oaks Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>03/01/2003</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>605 East Church Street</u> <u>Kewanee</u> <u>61443</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Henry</u>		(Signed) _____ (Date) _____	
Telephone Number: <u>(309) 852-3389</u> Fax # <u>(309) 853-1838</u>		(Type or Print Name) _____	
IDPA ID Number: <u>743055934002</u>		(Title) _____	
Date of Initial License for Current Owners: <u>03/01/2003</u>		(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____	
Type of Ownership:		(Print Name and Title) _____	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u>	
<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
In the event there are further questions about this report, please contact: Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page			

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Royal Oaks Care Center# 0046243 Report Period Beginning: 03/01/2003 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>200</u>	Skilled (SNF)	<u>200</u>	<u>61,200</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>200</u>	TOTALS	<u>200</u>	<u>61,200</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,902</u>	<u>7,305</u>	<u>1,150</u>	<u>25,357</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>16,902</u>	<u>7,305</u>	<u>1,150</u>	<u>25,357</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 41.43%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 03/01/2003

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 03/01/2003NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 200 and days of care provided 1,150Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Royal Oaks Care Center

0046243

Report Period Beginning:

03/01/2003

Ending:

12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	124,880	12,243	1,824	138,947		138,947	177	139,124			1
2	Food Purchase		111,537		111,537		111,537	(3,651)	107,886			2
3	Housekeeping	70,059	7,697		77,756		77,756		77,756			3
4	Laundry	54,151	11,708		65,859		65,859		65,859			4
5	Heat and Other Utilities			94,335	94,335		94,335	480	94,815			5
6	Maintenance	29,376	40,763	8,481	78,620		78,620	2,043	80,663			6
7	Other (specify):*											7
8	TOTAL General Services	278,466	183,948	104,640	567,054		567,054	(951)	566,103			8
	B. Health Care and Programs											
9	Medical Director			10,000	10,000		10,000		10,000			9
10	Nursing and Medical Records	917,110	83,152	2,726	1,002,988		1,002,988		1,002,988			10
10a	Therapy	5,343	496	1,316	7,155		7,155		7,155			10a
11	Activities	31,001	302		31,303		31,303		31,303			11
12	Social Services	35,845		13	35,858		35,858		35,858			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	989,299	83,950	14,055	1,087,304		1,087,304		1,087,304			16
	C. General Administration											
17	Administrative	66,388		16,360	82,748		82,748	(16,360)	66,388			17
18	Directors Fees											18
19	Professional Services			16,144	16,144		16,144	33,092	49,236			19
20	Dues, Fees, Subscriptions & Promotions			2,549	2,549		2,549	4,154	6,703			20
21	Clerical & General Office Expenses	72,101	3,935	71,637	147,673		147,673	12,386	160,059			21
22	Employee Benefits & Payroll Taxes			201,540	201,540		201,540	15,620	217,160			22
23	Inservice Training & Education			440	440		440	349	789			23
24	Travel and Seminar			515	515		515	1,187	1,702			24
25	Other Admin. Staff Transportation			2,576	2,576		2,576	1,263	3,839			25
26	Insurance-Prop.Liab.Malpractice			129,210	129,210		129,210	615	129,825			26
27	Other (specify):*											27
28	TOTAL General Administration	138,489	3,935	440,971	583,395		583,395	52,306	635,701			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,406,254	271,833	559,666	2,237,753		2,237,753	51,355	2,289,108			29

* Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			63,417	63,417		63,417	1,384	64,801			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			127,645	127,645		127,645	8,152	135,797			32
33	Real Estate Taxes			56,100	56,100		56,100		56,100			33
34	Rent-Facility & Grounds			(90)	(90)		(90)	2,289	2,199			34
35	Rent-Equipment & Vehicles			1,774	1,774		1,774	448	2,222			35
36	Other (specify):*											36
37	TOTAL Ownership			248,846	248,846		248,846	12,273	261,119			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		21,323		21,323		21,323		21,323			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			91,800	91,800		91,800		91,800			42
43	Other (specify):* Nonallowable Costs			14,604	14,604		14,604	(14,604)				43
44	TOTAL Special Cost Centers		21,323	106,404	127,727		127,727	(14,604)	113,123			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,406,254	293,156	914,916	2,614,326		2,614,326	49,024	2,663,350			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(1,412)	14		4
5 Telephone, TV & Radio in Resident Rooms	(1,784)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	(2,570)	30		9
10 Interest and Other Investment Income	(15)	25		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(504)	43		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(1,208)	43		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(23)	43		24
25 Fund Raising, Advertising and Promotional	(6,488)	43		25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See Schedule 5A	(7,056)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (21,060)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	70,084		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 70,084		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ 49,024		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
 (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Royal Oaks Care Center
Provider # 0046243
12/31/2003

Schedule 5A

VI. Adjustment Detail
Non-Allowable Expenses
Line 29 - Other

Description	Amount	Schedule V Reference
Offset Miscellaneous Income	(1,881)	21
Offset Vending Income	(578)	2
Disallow Special Events	(3,449)	43
Disallow Laboratory	(355)	43
Disallow Resident Flowers	(793)	43
Total	<u>(7,056)</u>	

See Accountants' Compilation Report

Royal Oaks Care Center

ID# 0046243

Report Period Beginning: 03/01/2003

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

See Accountants' Compilation Report

Summary A

12/31/03

[illegible]

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Royal Oaks Care Center# 0046243

Report Period Beginning:

03/01/2003 Ending:

12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(2,570)	3,954	0	0	0	0	0	0	0	0	0	1,384	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	8,167	0	0	0	0	0	0	0	0	8,167	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	2,289	0	0	0	0	0	0	0	0	2,289	34
35	Rent-Equipment & Vehicles	0	0	448	0	0	0	0	0	0	0	0	448	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(2,570)	3,954	10,904	0	0	0	0	0	0	0	0	12,288	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(10,007)	0	0	0	0	0	0	0	0	0	0	(10,007)	43
44	TOTAL Special Cost Centers	(10,007)	0	0	0	0	0	0	0	0	0	0	(10,007)	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(14,004)	32,471	10,904	26,709	0	0	0	0	0	0	0	56,080	45

Facility Name & ID Number Royal Oaks Care Center# 0046243

Report Period Beginning:

03/01/2003

Ending:

12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark Petersen	100	See attached Schedule 6A		See Attached Schedule 6A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	1 Dietary	\$	Petersen Health Care, Inc.	0.00%	\$ 177	\$ 177 1
2	V	5 Utilities		Petersen Health Care, Inc.	0.00%	480	480 2
3	V	6 Maintenance supplies		Petersen Health Care, Inc.	0.00%	2,043	2,043 3
4	V	17 Administrative	16,360	Petersen Health Care, Inc.	0.00%		(16,360) 4
5	V	19 Professional services		Petersen Health Care, Inc.	0.00%	11,268	11,268 5
6	V	20 Dues, fees & subscriptions		Petersen Health Care, Inc.	0.00%	245	245 6
7	V	21 Clerical & general office		Petersen Health Care, Inc.	0.00%	13,291	13,291 7
8	V	22 Employee benefits		Petersen Health Care, Inc.	0.00%	13,959	13,959 8
9	V	23 Inservice training & education		Petersen Health Care, Inc.	0.00%	349	349 9
10	V	24 Travel & seminar		Petersen Health Care, Inc.	0.00%	1,187	1,187 10
11	V	25 Other admin. staff transport		Petersen Health Care, Inc.	0.00%	1,263	1,263 11
12	V	26 Insurance-property & liab.		Petersen Health Care, Inc.	0.00%	615	615 12
13	V	30 Depreciation		Petersen Health Care, Inc.	0.00%	3,954	3,954 13
14	Total		\$ 16,360			\$ 48,831	\$ * 32,471 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Royal Oaks Care Center# 0046243Report Period Beginning: 03/01/2003 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	32 Interest	\$	Petersen Health Care, Inc.	0.00%	\$ 8,167	\$ 8,167	15
16	V	34 Rent-facility & grounds		Petersen Health Care, Inc.	0.00%	2,289	2,289	16
17	V	35 Rent-equipment & vehicles		Petersen Health Care, Inc.	0.00%	448	448	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 10,904	\$ * 10,904	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Royal Oaks Care Center# 0046243Report Period Beginning: 03/01/2003 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19 Professional services	\$	RLP Senior Villages, Inc.	0.00%	\$ 21,824	\$ 21,824	15
16	V	20 Dues, fees & subscriptions		RLP Senior Villages, Inc.	0.00%	3,909	3,909	16
17	V	21 Clerical & general office		RLP Senior Villages, Inc.	0.00%	976	976	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 26,709	\$ * 26,709	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Royal Oaks Care Center
provider # 0046243
12/31/2003

Schedule 6A

VII Related Parties - Page 6

All owned 100% by Mark Petersen

Related Nursing Homes

City

In-State:

Arcola Health Care Center	Arcola, IL
Bement Health Care Center	Bement, IL
Countryview Terrace	Louisville, IL
Eastview Terrace	Sullivan, IL
Havana Health Care Center	Havana, IL
Kewanee Care Home	Kewanee, IL
Palm Terrace of Mattoon	Mattoon, IL
Prairie Rose Health Care Center	Pana, IL
Robings Manor Nursing Home	Brighton, IL
Royal Oaks Care Center	Kewanee, IL
Sullivan Health Care Center	Sullivan, IL
Sunset Manor Nursing Home	Canton, IL

Out-of-State:

Meadow Lawn Nursing Center	Davenport, IA
----------------------------	---------------

Related Assisted Living

Courtyard Estates	Kewanee, IL
-------------------	-------------

Other Related Business Entities

Petersen Health Care Companies	Peoria, IL	Management/Bookkeeping
RLP Senior Villages, Inc.	Peoria, IL	Management/Bookkeeping

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Royal Oaks Care Center # 0046243 Report Period Beginning: 03/01/2003 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Mark Petersen	President	Administrative	100.00	324,112	5	10.00	Salary	\$ 28,388	L17,C1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 28,388		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Royal Oaks Care Center
provider # 0046243
12/31/2003

Schedule 7A

VII Related Parties

C Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors

Name	Arcola Health Care Center	Bement Health Care Center	Countryview Terrace	Eastview Terrace	Havana Health Care Center	Kewanee Care Center	Meadow Lawn Nursing Center	Palm Terrace of Mattoon	Prairie Rose Health Care Center	Robings Manor Nursing Home	Royal Oaks Care Center	Sullivan Health Care Center	Sunset Manor Nursing Home	TOTAL
Mark Petersen	37,699	23,276	6,197	22,462	32,710	28,962	25,443	34,589	35,181	26,725	28,388	9,151	41,717	352,500

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Royal Oaks Care Center# 0046243 Report Period Beginning: 03/01/2003 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Petersen Health Care Companies
 Street Address 7218 North Villa Lake
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1 Dietary	Patient days	315,110	13	\$ 2,200	\$	25,377	\$ 177	1
2	5 Utilities	Patient days	315,110	13	5,963		25,377	480	2
3	6 Maintenance supplies	Patient days	315,110	13	25,373		25,377	2,043	3
4	19 Professional services	Patient days	315,110	13	139,914		25,377	11,268	4
5	20 Dues, fees & subscriptions	Patient days	315,110	13	3,044		25,377	245	5
6	21 Clerical & general office	Patient days	315,110	13	165,031		25,377	13,291	6
7	22 Employee benefits	Patient days	315,110	13	173,328		25,377	13,959	7
8	23 Inservice training & education	Patient days	315,110	13	4,328		25,377	349	8
9	24 Travel & seminar	Patient days	315,110	13	14,743		25,377	1,187	9
10	25 Other admin. staff transport	Patient days	315,110	13	15,681		25,377	1,263	10
11	26 Insurance-property & liab.	Patient days	315,110	13	7,635		25,377	615	11
12	30 Depreciation	Patient days	315,110	13	49,093		25,377	3,954	12
13	32 Interest	Patient days	315,110	13	101,410		25,377	8,167	13
14	34 Rent-facility & grounds	Patient days	315,110	13	28,419		25,377	2,289	14
15	35 Rent-equipment & vehicles	Patient days	315,110	13	5,568		25,377	448	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 741,730	\$		\$ 59,735	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Royal Oaks Care Center# 0046243 Report Period Beginning: 03/01/2003 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization RLP Senior Villages, Inc.
 Street Address 7218 North Villa Lake
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional services	Patient days	64,477	3	\$ 55,451	\$ 25,377	\$ 21,824	1
2	20	Dues, fees & subscriptions	Patient days	64,477	3	1,725	25,377	679	2
3	20	Dues, fees & subscriptions	Direct cost	64,477	1		1	3,230	3
4	21	Clerical & general office	Patient days	64,477	3	2,480	25,377	976	4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 59,656	\$		\$ 26,709	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Royal Oaks Care Center# 0046243

Report Period Beginning:

03/01/2003

Ending:

12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Associated Bank		X	Mortgage	\$22,519.00	09/20/03	\$ 2,685,557	\$ 2,672,231	09/20/33	0.0645	\$ 124,148	1	
2	Ford Credit		X	Vehicle	\$541.00	04/17/03	30,965	27,004	04/17/08	0.0550	370	2	
3	Citizens Bank		X	Mortgage	\$20,686.00	04/01/03	2,400,000		09/20/03	0.0645	3,127	3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related				\$43,746.00		\$ 5,116,522	\$ 2,699,235			\$ 127,645	9	
	B. Non-Facility Related*												
10								Offset Interest Income			(15)	10	
11												11	
12												12	
13								Allocated from Management Co.			8,167	13	
14	TOTAL Non-Facility Related						\$	\$			\$ 8,152	14	
15	TOTALS (line 9+line14)						\$ 5,116,522	\$ 2,699,235			\$ 135,797	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Royal Oaks Care Center**# **0046243** Report Period Beginning: **03/01/2003** Ending: **12/31/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>			
1. Real Estate Tax accrual used on 2002 report.		\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	\$	2
3. Under or (over) accrual (line 2 minus line 1).		\$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 56,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 56,100	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998	8	
	1999	9	
	2000	10	
	2001	11	
	2002	56,100	12

	FOR OHF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2002 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATION \$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY IDPH LICENSE NUMBER 0046243

TELEPHONE (309) 691-8113 FAX#: (309) 691-8622

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

B. Real Estate Tax Cost Allocations

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Page 10A

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 35,875 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
 If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	362,419	2003	\$ 200,000	1
2					2
3	TOTALS	362,419		\$ 200,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

03/01/2003 Ending: 12/31/03

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,473,853	\$ 20,593		\$ 21,060	\$ 467	\$ 21,060	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$	\$	\$	\$		\$	71
72	Current Year Purchases	513,583	24,980	36,684	11,704	7	36,685	72
73	Fully Depreciated Assets							73
74	Allocated from Management Co.			3,954	3,954			74
75	TOTALS	\$ 513,583	\$ 24,980	\$ 40,638	\$ 15,658		\$ 36,685	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2003 Ford Van	2003	\$ 31,033	\$ 17,844	\$ 3,103	\$ (14,741)	5	\$ 3,103	76
77										77
78										78
79										79
80	TOTALS			\$ 31,033	\$ 17,844	\$ 3,103	\$ (14,741)		\$ 3,103	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,218,469	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 63,417	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 64,801	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 1,384	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 60,848	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	N/A				87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93	N/A		93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocated from Management Co.				2,199			6
7	TOTAL				\$ 2,199			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A.

N/A

N/A

9. Option to Buy: ☐ YES ☐ NO Terms: N/A*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 2,222 Description: Copier \$1,774; Allocated from Management Co. \$448

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18			<u>N/A</u>		18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$

13. /2005 \$

14. /2006 \$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? It is the policy of this facility to only hire certified nurses aides. If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
--	--	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist	L10a, C3	134 hrs	5,343				134	5,343	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C2	hrs				496		496	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescripts				21,323		21,323	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$ 5,343		\$	\$ 21,819	134	\$ 27,162	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Royal Oaks Care Center

Provider #: 0046243

03/01/2003 to 12/31/03

Schedule 16A

XIV. Special Services

Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
	L39, C3			
	L39, C3			
	L39, C3			
	L39, C3			
Total			0	0

See Accountants' Compilation Report

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning: 03/01/2003

Ending:

12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/03

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 374,515	\$ 374,515	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance <u>None</u>)	461,953	461,953	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	64,654	64,654	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <u>See Schedule 17A</u>	86,630	86,630	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 987,752	\$ 987,752	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	200,000	200,000	13
14	Buildings, at Historical Cost	1,473,853	1,473,853	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	544,616	544,616	16
17	Accumulated Depreciation (book methods)	(63,417)	(60,848)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify) <u>Loan Costs</u>	18,193	18,193	22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,173,245	\$ 2,175,814	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,160,997	\$ 3,163,566	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 205,072	\$ 205,072	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	66,200	66,200	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	56,100	56,100	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	60,279	60,279	36
37	<u>See Schedule 17A</u>	101,428	101,428	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 489,079	\$ 489,079	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	27,004	27,004	39
40	Mortgage Payable	2,672,231	2,672,231	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,699,235	\$ 2,699,235	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,188,314	\$ 3,188,314	46
47	TOTAL EQUITY (page 18, line 24)	\$ (27,317)	\$ (24,748)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,160,997	\$ 3,163,566	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name Royal Oaks Care Center
PROVIDER # 0046243
Period Ending 12/31/2003

Schedule 17A

XV. BALANCE SHEET

A. Current Assets

Line 9, Other Current Assets

	Operating	After Consolidation
Assessments	51,630	51,630
Intercompany - Courtyard Estates	35,000	35,000
	<u>86,630</u>	<u>86,630</u>

C. Current Liabilities

Line 36, Other Current Liabilities (specify):

	Operating	After Consolidation
Accrued Vacation	47,260	47,260
Other Withholding	601	601
Accrued Sales Tax	121	121
Other Accrued Expenses	3,030	3,030
Accrued Insurance	9,267	9,267
	<u>60,279</u>	<u>60,279</u>
Total		

C. Current Liabilities

Line 37, Other Current Liabilities (specify):

	Operating	After Consolidation
Accounts Payable - Prior Owner	24,771	24,771
Intercompany - PHC	2,040	2,040
Intercompany - Palm Terrace	74,617	74,617
	<u>101,428</u>	<u>101,428</u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(2,317)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(25,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (27,317)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (27,317)	24

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 19

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning: 03/01/2003

Ending:

12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,388,132	1
2	Discounts and Allowances for all Levels	87,378	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,475,510	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	113,831	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 113,831	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,412	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	14,166	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,156	19
20	Radiology and X-Ray		20
21	Other Medical Services	460	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 20,194	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	15	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Schedule 19A</u>	2,459	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 2,459	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,612,009	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	567,054	31
32	Health Care	1,087,304	32
33	General Administration	583,395	33
B. Capital Expense			
34	Ownership	248,846	34
C. Ancillary Expense			
35	Special Cost Centers	35,927	35
36	Provider Participation Fee	91,800	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,614,326	40
41	Income before Income Taxes (line 30 minus line 40)**	(2,317)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (2,317)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
Entity is a cash basis tax payer.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name Royal Oaks Care Center
PROVIDER # 0046243
Period Ending 12/31/2003

Schedule 19 A

XVII. INCOME STATEMENT

E. Other Revenue

	<u>Amount</u>
Vending	578
Miscellaneous	1,881
Total	<u><u>2,459</u></u>

See Accountants' Compilation Report

Facility Name & ID Number Royal Oaks Care Center

0046243

Report Period Beginning: 03/01/2003

Ending:

12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,253	1,253	\$ 29,732	\$ 23.73	1
2	Assistant Director of Nursing	1,719	1,719	31,584	18.37	2
3	Registered Nurses	6,316	6,323	110,572	17.49	3
4	Licensed Practical Nurses	14,985	15,031	218,840	14.56	4
5	Nurse Aides & Orderlies	42,809	42,809	393,468	9.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	134	134	5,343	39.87	7
8	Rehab/Therapy Aides	3,972	3,972	79,967	20.13	8
9	Activity Director	1,733	1,733	12,719	7.34	9
10	Activity Assistants	1,741	1,741	18,282	10.50	10
11	Social Service Workers	3,106	3,192	35,845	11.23	11
12	Dietician					12
13	Food Service Supervisor	2,083	2,083	19,845	9.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,055	13,066	105,035	8.04	15
16	Dishwashers					16
17	Maintenance Workers	2,719	2,719	29,376	10.80	17
18	Housekeepers	11,113	11,113	70,059	6.30	18
19	Laundry	6,333	6,333	54,151	8.55	19
20	Administrator	1,733	1,733	38,000	21.93	20
21	Assistant Administrator					21
22	Other Administrative	168	168	28,388	168.98	22
23	Office Manager					23
24	Clerical	5,250	5,250	72,101	13.73	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,268	1,268	16,643	13.13	31
32	Other Health Care Plan Coord.	1,804	1,804	36,304	20.12	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,294	123,444	\$ 1,406,254 *	\$ 11.39	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	10,000	L9, C3	36
37	Medical Records Consultant	Monthly	1,213	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	8	400	L10, C3	39
40	Physical Therapy Consultant	18	1,316	L10a, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) Rehab Consultant	15	1,113	L10, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	41	\$ 14,042		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses	N/A			51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Royal Oaks Care Center**

XIX. SUPPORT SCHEDULES

STATE OF ILLINOIS

0046243

Page 21

Report Period Beginning: **03/01/2003** Ending: **12/31/03**

A. Administrative Salaries <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;">Name</th> <th style="width: 10%;">Function</th> <th style="width: 10%;">Ownership %</th> <th style="width: 10%;">Amount</th> </tr> </thead> <tbody> <tr> <td>Angela Harris</td> <td>Administrator</td> <td>0</td> <td style="text-align: right;">\$ 38,000</td> </tr> <tr> <td>Mark Petersen</td> <td>Administrative</td> <td>100</td> <td style="text-align: right;">28,388</td> </tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr> <td colspan="3">TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)</td> <td style="text-align: right;">\$ 66,388</td> </tr> </tbody> </table>				Name	Function	Ownership %	Amount	Angela Harris	Administrator	0	\$ 38,000	Mark Petersen	Administrative	100	28,388													TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 66,388	D. Employee Benefits and Payroll Taxes <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Description</th> <th style="width: 10%;">Amount</th> </tr> </thead> <tbody> <tr><td>Workers' Compensation Insurance</td><td style="text-align: right;">\$ 212</td></tr> <tr><td>Unemployment Compensation Insurance</td><td style="text-align: right;">39,311</td></tr> <tr><td>FICA Taxes</td><td style="text-align: right;">92,070</td></tr> <tr><td>Employee Health Insurance</td><td style="text-align: right;">39,099</td></tr> <tr><td>Employee Meals</td><td style="text-align: right;">1,661</td></tr> <tr><td>Illinois Municipal Retirement Fund (IMRF)*</td><td> </td></tr> <tr><td>Life Insurance</td><td style="text-align: right;">224</td></tr> <tr><td>Employee Relations</td><td style="text-align: right;">30,532</td></tr> <tr><td>401-K Matching</td><td style="text-align: right;">92</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td>Allocated from Management Co.</td><td style="text-align: right;">13,959</td></tr> <tr><td> </td><td> </td></tr> <tr> <td>TOTAL (agree to Schedule V, line 22, col.8)</td> <td style="text-align: right;">\$ 217,160</td> </tr> </tbody> </table>				Description	Amount	Workers' Compensation Insurance	\$ 212	Unemployment Compensation Insurance	39,311	FICA Taxes	92,070	Employee Health Insurance	39,099	Employee Meals	1,661	Illinois Municipal Retirement Fund (IMRF)*		Life Insurance	224	Employee Relations	30,532	401-K Matching	92					Allocated from Management Co.	13,959			TOTAL (agree to Schedule V, line 22, col.8)	\$ 217,160	F. Dues, Fees, Subscriptions and Promotions <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 60%;">Description</th> <th style="width: 10%;">Amount</th> </tr> </thead> <tbody> <tr><td>IDPH License Fee</td><td style="text-align: right;">\$ 804</td></tr> <tr><td>Advertising: Employee Recruitment</td><td style="text-align: right;">804</td></tr> <tr><td>Health Care Worker Background Check (Indicate # of checks performed <u>62</u>)</td><td style="text-align: right;">742</td></tr> <tr><td>Miscellaneous Dues & Subscriptions</td><td style="text-align: right;">375</td></tr> <tr><td>Miscellaneous Licenses & Permits</td><td style="text-align: right;">628</td></tr> <tr><td> </td><td> </td></tr> <tr><td>Allocated from Management Co.</td><td style="text-align: right;">4,154</td></tr> <tr><td> </td><td> </td></tr> <tr><td> </td><td> </td></tr> <tr><td>Less: Public Relations Expense</td><td style="text-align: right;">()</td></tr> <tr><td>Non-allowable advertising</td><td style="text-align: right;">()</td></tr> <tr><td>Yellow page advertising</td><td style="text-align: right;">()</td></tr> <tr> <td>TOTAL (agree to Sch. V, line 20, col. 8)</td> <td style="text-align: right;">\$ 6,703</td> </tr> </tbody> </table>				Description	Amount	IDPH License Fee	\$ 804	Advertising: Employee Recruitment	804	Health Care Worker Background Check (Indicate # of checks performed <u>62</u>)	742	Miscellaneous Dues & Subscriptions	375	Miscellaneous Licenses & Permits	628			Allocated from Management Co.	4,154					Less: Public Relations Expense	()	Non-allowable advertising	()	Yellow page advertising	()	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 6,703
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* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

Royal Oaks Care Center
Provider #: 0046243
03/01/2003 to 12/31/03

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	16,144
---	---------------

Allocated from Management Company	Legal	15,080
--	--------------	---------------

Allocated from Management Company	Other	18,012
--	--------------	---------------

Total (agree to Schedule V, line 19, column 8)	49,236
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See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

Amount of Expense Amortized Per Year													
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Royal Oaks Care Center

STATE OF ILLINOIS

0046243

Report Period Beginning: 03/01/2003

Page 23

Ending: 12/31/03

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No
If YES, give association name and amount. N/A
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 6,655 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 91,800
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 1,661 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Ginoli & Company The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT

Royal Oaks Care Center

01:11 PM 11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	49,024	equal to	49,024	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	135,797	equal to	135,797	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	56,100	equal to	56,100	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	64,801	equal to	64,801	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	2,199	equal to	2,199	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	2,222	equal to	2,222	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages	5,343	equal to	0	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	7,155	equal to	7,155	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies	21,819	equal to	21,819	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	567,054	equal to	567,054	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,087,304	equal to	1,087,304	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	583,395	equal to	583,395	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	248,846	equal to	248,846	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	35,927	equal to	35,927	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	91,800	equal to	91,800	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	800,839	equal to	917,110	-116,271	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to	0	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	5,343	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	31,001	equal to	31,001	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	35,845	equal to	35,845	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	124,880	equal to	124,880	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	29,376	equal to	29,376	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	70,059	equal to	70,059	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	54,151	equal to	54,151	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	66,388	equal to	66,388	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	72,101	equal to	72,101	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,406,254	equal to	1,406,254	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	1,824	-1,824	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	10,000	< or = to	10,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	1,613	< or = to	2,726	-1,113	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	0	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	13	-13	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	66,388	equal to	66,388	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	16,360	equal to	16,360	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	16,144	equal to	16,144	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	217,160	equal to	217,160	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	6,703	equal to	6,703	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,702	equal to	1,702	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	91,800	equal to	91,800	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	1,661	< or = to	15,620	-13,959	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	1,661	equal to	1,661	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to	0	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,150	equal to	1,150	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	70,084	equal to	70,084	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	2,699,235	equal to	2,699,235	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	56,100	equal to	56,100	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	200,000	equal to	200,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,473,853	equal to	1,473,853	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	544,616	equal to	544,616	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	60,848	equal to	60,848	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-27,317	equal to	-27,317	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-2,317	equal to	-2,317	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,160,997	equal to	3,160,997	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses	VISA MILE CHARGES THE SUPPORT CALC. THIS IS LEAD TO THE COST REPORT			01/11/2016
VISA Number	Number	Description of Cost Center		
Cost report period	From	To	Rate Number	
Wk 14 on 01/02/16 facility, enter a 1 in cell 1	01/02/2016	01/02/2016		
Account total days	01/02/2016	01/02/2016	25,302 Pct. of occupancy	81.43%
Unlabeled Public Aid Support/Fuel	0			
Cost Services Salary/Wage	275,480 Cost 1, Line 8 - (check tag)			
Cost Admin Salary/Wage	1,000,000 Cost 1, Line 8 - (check tag)			
Total Salary Wage	1,400,250 Cost 1, Line 8 - (check tag)			
Employee Benefits	217,160 Cost 1, Line 22 - (check tag)			
Total General Services	666,100 Cost 1, Line 8 - (check tag)			
Total General Services	666,750 Cost 1, Line 28 - (check tag)			

[illegible]

Adjust Report Service (Enables the Inflation)

To calculate the impact of inflation, adjust the Inflation Rates used for the General Fund and the General Administration parts of your cost report. These inflation factors are based on the Federal Inflation Publication. To enter the appropriate inflation factors, you must first enter your latest number using the formula provided. Once you have calculated your latest number, click on the **Adjust Inflation Factors** option corresponding to your latest number and save before you updating your report cost.

Answer Number: Calculations

Convert the beginning and ending dates of your most reporting period to 1. Determine that your report report your number and apply the following formula:

Beginning Date + Ending Month
Ending Date = Ending Year
Ending Year = Ending Year + 2000

Sum of the three lines
Subtract them from the

11 divided by 2 = 5.5
32 subtract by 5.5 = 26.5
2000 subtract by 5 =

8. **Enter the appropriate Inflation Multiplier**

Find Inflation Multiplier, and find Inflation Multiplier entered in the last number you have calculated

General Services Multiplier
General Administration Multiplier

9. **Apply Inflation Multipliers to Update Cite**

- 1) **Multiply New Total General Services Cite**
Step 1-1 by the appropriate multiplier from Table 1
- 2) **Multiply New Total General Administration Cite**
Step 1-2 by the appropriate multiplier from Table 1
- 3) **Multiply New Total General Support Cites**
Step 1-3 by the appropriate multiplier from Table 1
- 4) **Update General Services Cite**
- 5) **Update General Administration Cite**
- 6) **Update General Support Cites**

[illegible][illegible]

Lipid		
Lipid Modulators		
Base	General	General
Number	Number	Number
242	1.11-162	1.16-202
243	1.11-171	1.16-203
244	1.12-171	1.16-276
245	1.12-172	1.16-277
246	1.12-173	1.16-278
247	1.12-174	1.16-279
248	1.12-175	1.16-280
249	1.12-176	1.16-281
250	1.12-177	1.16-282
251	1.12-178	1.16-283
252	1.12-179	1.16-284
253	1.12-180	1.16-285
254	1.12-181	1.16-286
255	1.12-182	1.16-287
256	1.12-183	1.16-288
257	1.12-184	1.16-289
258	1.12-185	1.16-290
259	1.12-186	1.16-291
260	1.12-187	1.16-292
261	1.12-188	1.16-293
262	1.12-189	1.16-294
263	1.12-190	1.16-295
264	1.12-191	1.16-296
265	1.12-192	1.16-297
266	1.12-193	1.16-298
267	1.12-194	1.16-299
268	1.12-195	1.16-300
269	1.12-196	1.16-301
270	1.12-197	1.16-302
271	1.12-198	1.16-303
272	1.12-199	1.16-304
273	1.12-200	1.16-305
274	1.12-201	1.16-306
275	1.12-202	1.16-307
276	1.12-203	1.16-308
277	1.12-204	1.16-309
278	1.12-205	1.16-310
279	1.12-206	1.16-311
280	1.12-207	1.16-312
281	1.12-208	1.16-313
282	1.12-209	1.16-314
283	1.12-210	1.16-315
284	1.12-211	1.16-316
285	1.12-212	1.16-317
286	1.12-213	1.16-318
287	1.12-214	1.16-319
288	1.12-215	1.16-320
289	1.12-216	1.16-321
290	1.12-217	1.16-322
291	1.12-218	1.16-323
292	1.12-219	1.16-324
293	1.12-220	1.16-325
294	1.12-221	1.16-326
295	1.12-222	1.16-327
296	1.12-223	1.16-328
297	1.12-224	1.16-329
298	1.12-225	1.16-330
299	1.12-226	1.16-331
300	1.12-227	1.16-332
301	1.12-228	1.16-333
302	1.12-229	1.16-334
303	1.12-230	1.16-335
304	1.12-231	1.16-336
305	1.12-232	1.16-337
306	1.12-233	1.16-338
307	1.12-234	1.16-339
308	1.12-235	1.16-340
309	1.12-236	1.16-341
310	1.12-237	1.16-342
311	1.12-238	1.16-343
312	1.12-239	1.16-344
313	1.12-240	1.16-345
314	1.12-241	1.16-346
315	1.12-242	1.16-347
316	1.12-243	1.16-348
317	1.12-244	1.16-349
318	1.12-245	1.16-350
319	1.12-246	1.16-351
320	1.12-247	1.16-352
321	1.12-248	1.16-353
322	1.12-249	1.16-354
323	1.12-250	1.16-355
324	1.12-251	1.16-356
325	1.12-252	1.16-357
326	1.12-253	1.16-358
327	1.12-254	1.16-359
328	1.12-255	1.16-360
329	1.12-256	1.16-361
330	1.12-257	1.16-362
331	1.12-258	1.16-363
332	1.12-259	1.16-364
333	1.12-260	1.16-365
334	1.12-261	1.16-366
335	1.12-262	1.16-367
336	1.12-263	1.16-368
337	1.12-264	1.16-369
338	1.12-265	1.16-370
339	1.12-266	1.16-371
340	1.12-267	1.16-372
341	1.12-268	1.16-373
342	1.12-269	1.16-374
343	1.12-270	1.16-375
34		

	75m	30m	Relative 30m
Index	Percentage	Percentage	Percentage
1	37.33	34.77	0.93
2	34.36	26.73	0.78
3	37.33	34.77	0.93
4	32.49	27.63	0.85
5	43.83	34.76	0.87
6	43.83	34.76	0.87
7	43.83	34.76	0.87
8	50.02	30.57	0.61
9	40.58	30.58	0.75
10	36.83	30.58	0.83

276	1.0000	1.0000
277	1.0750	1.0000
278	1.0750	1.0001
279	1.0750	1.0000
279	1.0000	1.0000
280	1.0001	1.0000
281	1.0007	1.0000
282	1.0000	1.0750
282	1.0000	1.0751
283	1.0070	1.0750
285	1.0000	1.0000
286	1.0001	1.0000
287	1.0002	1.0007
288	1.0003	1.0004
289	1.0000	1.0000
290	1.0004	1.0001
291	1.0001	1.0000
292	1.0007	1.0000
293	1.0003	1.0000
294	1.0000	1.0000
295	1.0000	1.0007
296	1.0000	1.0007
297	1.0000	1.0007
298	1.0004	1.0000
299	1.0000	1.0007
300	1.0000	1.0000
301	1.0100	1.0000
302	1.0000	1.0000
303	1.0007	1.0000
304	1.0007	1.0000
305	1.0000	1.0000
306	1.0007	1.0000

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	124,880	12,243	1,824	138,947	0	138,947	177	139,124
2. Food Purchase	0	111,537	0	111,537	0	111,537	-3,651	107,886
3. Housekeeping	70,059	7,697	0	77,756	0	77,756	0	77,756
4. Laundry	54,151	11,708	0	65,859	0	65,859	0	65,859
5. Heat and Other Utilities	0	0	94,335	94,335	0	94,335	480	94,815
6. Maintenance	29,376	40,763	8,481	78,620	0	78,620	2,043	80,663
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	278,466	183,948	104,640	567,054	0	567,054	-951	566,103
9. Medical Director	0	0	10,000	10,000	0	10,000	0	10,000
10. Nursing & Medical Records	917,110	83,152	2,726	1,002,988	0	1,002,988	0	1,002,988
10a. Therapy	5,343	496	1,316	7,155	0	7,155	0	7,155
11. Activities	31,001	302	0	31,303	0	31,303	0	31,303
12. Social Services	35,845	0	13	35,858	0	35,858	0	35,858
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	989,299	83,950	14,055	1,087,304	0	1,087,304	0	1,087,304
17. Administrative	66,388	0	16,360	82,748	0	82,748	-16,360	66,388
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	16,144	16,144	0	16,144	33,092	49,236
20. Fees, Subscriptions & Promotion	0	0	2,549	2,549	0	2,549	4,154	6,703
21. Clerical & General Office	72,101	3,935	71,637	147,673	0	147,673	12,386	160,059
22. Employee Benefits & Payroll	0	0	201,540	201,540	0	201,540	15,620	217,160
23. Inservice Training & Education	0	0	440	440	0	440	349	789
24. Travel and Seminar	0	0	515	515	0	515	1,187	1,702
25. Other Admin. Staff Trans	0	0	2,576	2,576	0	2,576	1,263	3,839
26. Insurance-Prop.Liab.Malpractice	0	0	129,210	129,210	0	129,210	615	129,825
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	138,489	3,935	440,971	583,395	0	583,395	52,306	635,701
29. Total General Administrative	1,406,254	271,833	559,666	2,237,753	0	2,237,753	51,355	2,289,108
30. Depreciation	0	0	63,417	63,417	0	63,417	1,384	64,801
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	127,645	127,645	0	127,645	8,152	135,797
33. Real Estate	0	0	56,100	56,100	0	56,100	0	56,100
34. Rent - Facility & Grounds	0	0	-90	-90	0	-90	2,289	2,199
35. Rent - Equipment & Vehicles	0	0	1,774	1,774	0	1,774	448	2,222
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	248,846	248,846	0	248,846	12,273	261,119
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	21,323	0	21,323	0	21,323	0	21,323
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	91,800	91,800	0	91,800	0	91,800
43. Other (specify):*	0	0	14,604	14,604	0	14,604	-14,604	0
44. Total Special Cost Ce	0	21,323	106,404	127,727	0	127,727	-14,604	113,123
45. Grand Total	1,406,254	293,156	914,916	2,614,326	0	2,614,326	49,024	2,663,350

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on hand and in banks	374,515	374,515
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	461,953	461,953
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	64,654	64,654
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	86,630	86,630
10. Total current assets	987,752	987,752
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	200,000	200,000
14. Buildings, at Historical Cost	1,473,853	1,473,853
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	544,616	544,616
17. Accumulated Depreciation (book methods)	-63,417	-60,848
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	18,193	18,193
23. other (specify):	0	0
24. Total Long-Term Assets	2,173,245	2,175,814
25. Total Assets	3,160,997	3,163,566
CURRENT LIABILITIES		
26. Accounts Payable	205,072	205,072
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	66,200	66,200
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	56,100	56,100
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	60,279	60,279
37. Other Current Liabilities (specify):	101,428	101,428
38. Total Current Liabilities	489,079	489,079
LONG TERM LIABILITES		
39. Long-Term Notes Payable	27,004	27,004
40. Mortgage Payable	2,672,231	2,672,231
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	2,699,235	2,699,235
46. Total Liabilities	3,188,314	3,188,314
47. Total Equity	-27,317	-24,748
48. Total Liabilities and Equity	3,160,997	3,163,566

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,388,132
2. Discounts and Allowances for all Levels	87,378
Subtotal - Inpatient Care	2,475,510
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	113,831
7. Oxygen	0
Subtotal - Ancillary Revenue	113,831
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	1,412
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	14,166
18. Sale of Supplies to Non-Patients	0
19. Laboratory	4,156
20. Radiology and X-Ray	0
21. Other Medical Services	460
22. Laundry	0
Subtotal - Other Operating Revenue	20,194
24. Contributions	0
25. Interest and Other Investments Income	15
Subtotal - Non-Operating Revenue	15
27. Other Revenue (specify):	2,459
28. Other Revenue (specify):	0
Subtotal - Other Revenue	2,459
30. Total Revenue	2,612,009
31. General Services	567,054
32. Health Care	1,087,304
33. General Administration	583,395
34. Ownership	248,846
35. Special Cost Centers	35,927
35. Provider Participation Fee	91,800
37. Other	0
40. Total Expenses	2,614,326
41. Income Before Income Taxes	-2,317
42. Income Taxes	0
43. Net Income or Loss for the Year	-2,317

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23 Provider Participation fee is linked from page 4